DOCUMENT RESUME

ED 211 906 CG 015 699

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TITLE Reconciling Feminism and Psychoanalysis: The Patient as Therapist to the Therapist.
PUB DATE Aug 81
NOTE 14p.; Paper presented at the Annual Convention of the American Psychological Association (89th, Los Angeles, CA, August 24-26, 1981).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Counseling Techniques; Counselor Characteristics; *Counselor Client Relationship; *Females; *Feminism; Helping Relationship; *Individual Development; Interpersonal Relationship; Psychiatry; Psychopathology; *Psychotherapy; State of the Art Reviews; Therapeutic Environment

ABSTRACT

Although incompatible differences appear to exist between psychoanalytic therapy, which involves a hierarchical relationship, and feminism, which stresses egalitarian values, some versions of psychoanalytic theory are able to maintain their hierarchy within a context consistent with feminist values. Freud touched on the importance of the two-person relationship in therapy; neo-Freudians and object-relation theorists brought a major shift toward comprehending psychopathology as an interpersonal phenomenon. Feminist criticism of the therapeutic relationship as abusive is refuted in discussions of the real nontransference aspects of the psychoanalytic situation. Although feminists have suggested that the patient in therapy is disempowered, there can be considerable power and respect given to the patient. One aspect of psychoanalytic therapy consistent with feminist ideas concerns the patient's self-curative capacity and active participation in change which empowers the patient, reduces arbitrary authority, and enhances mutuality. Recognition of the therapist's humanness, fallibility, and unconscious conflicts, as well as the patient's perceptions of countertransference in the therapist and the patient's subsequent restitutive attempts, contribute to a more liberating clarification of analytic practice. (NRB)

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RECONCILING FEMINISM AND PSYCHOANALYSIS: THE PATIENT AS THERAPIST TO THE THERAPIST

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Presented as part of a symposium "New Visions of Psychotherapy in Light of Feminism and Psychoanalysis", at the American Psychological Association, Los Angeles, California. August, 1981.

The therapeutic relationship in psychoanalysis or psychoanalytically oriented psychotherapy, where the therapist can be viewed as healthy, powerful, objective and omniscient, and the patient seen as sick, dependent, emotionally confused, and even submissive, has been described as one which recreates the patriarchal structure of Western culture (Chesler, 1976; Foucault, 1965; Franks, 1979; Rohrbaugh, 1979). Not only do mental health professionals have different definitions of mental health for men and women (Broverman et al., 1970), but traditional therapists have been criticized for working within a relationship that implicitly encourages and perpetuates dependency, passivity, and reliance on dominant authority for help, and thereby violates feminist therapeutic goals of empowering, trusting, and respecting patients. Linking the institutions of psychotherapy and marriage, Chesler (1971) contends that both are vehicles of social control and oppression of women, mirroring and supporting a sexist hierarchy in each other. This position is given added credence by the fact that most psychiatric patients, whether documented by community studies, private doctors' records, first hospital admissions, private or public outpatient psychiatric centers, are women (Gove & Tudor, 1973), while most therapists are men (Chesler, 1971). This demographic finding highlights, in microcosm, the extent to which men have more power than women in our society, and sets the stage for the abuse of the imbalance of power between a therapist and a help-seeking patient.

It has been suggested that there are incompatible differences in the styles and goals of psychoanalytically oriented therapy and feminist or radical tenets that uphold egalitarian values and the empowerment of women (Rawlings & Carter, 1977; Steiner, 1971; Rohrbaugh, 1979). In fact,

it is based on these seemingly inconsistent ideologies that self-identified "radical" therapists have condemned and even dismissed as hopelessly destructive, more traditional psychoanalytically oriented therapies. Although the psychoanalytic therapy relationship can evolve into an arbitrary or rigid hierarchical one, I will discuss versions of psychoanalytic theory and technique that maintain the hierarchy, but do so within a context that is consistent with feminist values.

While some feminists (Rawlings & Carter, 1977) have rejected the hierarchy entirely, and have advocated an egalitarian and fully reciprocal relationship between therapist and patient where all information and feelings are shared mutually, this framework seems unrealistic in light of a patient's request for expert help, and a therapist's capacity to give. However, this imbalance of power need not be detrimental to the patient. If proper attention is paid to the actual therapeutic interaction, then, when distortions in perception, conflicts between patient and therapist, or emotional blocks to therapeutic progress arise, the therapist is obligated to consider the ways in which s/he, as well as the patient, may be actively contributing to the situation. In essence, this represents a translation of the feminist goals of respect and empowerment to the level and appreciation of unconscious communication, and demonstrates some characteristics of psychoanalysis that make it consistent with, and exemplary of, feminist values.

Beginning with traces in Freud's (1912; 1910; 1937) writings, and later in developments by the interpersonal psychiatrists Sullivan (1970) and Fromm-Reichman (1950), and most recently and explicitly, in the work of Searles (1979), Greenson (1974), and Langs (1976; 1978), there is growing emphasis on the role of the therapist in re-enacting and compre-

hending the patient's pathology. The view that emotional difficulties are interpersonal difficulties demands that adequate analysis of thoughts, feelings, and processes take place within an interpersonal relationship that is open to investigation. This conceptualization of therapy as a bi-personal field where both therapist and patient have interacting unconscious fears, wishes, needs, and conflicts, begins to bridge the gap between traditional and feminist therapies. After briefly acknowledging the historical roots of such a perspective, I will explore the ways in which patients have been seen by some psychoanalysts to enable therapeutic work to progress and create a therapeutic working alliance by unconsciously acting as therapists or supervisors to their therapists.

Even in his early technique papers, Freud (1910) considers the extent to which a therapist can overcome his/her countertransference as a key to the management of the patient's analysis. He advocates self-analysis on a continuing and deepening basis while working with patients, even stating that lack of success in self-analysis precludes any successful treatment of patients (Freud, 1937). Although he brings our attention to it, Freud does not develop this kernel that implicates the importance of this two-person relationship; his theory is primarily an instinct theory and he concentrates on the patient's transference as it reflects the unconscious.

With the neo-Freudians, such as Sullivan, Fromm-Reichman, and Searles in this country, and the British object-relation theorists including Fairbairn (1962) and Winnicott (1979), a major shift toward comprehending psychopathology as an interpersonal phenomenon occurs. Consequently, the patient-therapist relationship becomes the new arena for expressing and

working through intrapsychic and interpersonal pain. The process of patient-therapist interaction, rather than simply the content of patient communications, magnifies in importance; in this way the therapist as well as the patient is exposed and vulnerable to analysis and emotion, mandating attention to the therapist's countertransference experiences.

Feminists have criticized the relationship in therapy as potentially abusive, particularly when attention to the relationship has focused on the patient's pathological distortions of the therapist. Numerous analysts have addressed this issue in discussion of the real nontransference aspects of the psychoanalytic situation. Fairbairn (1958), who teaches that instincts are crucial only so far as they are relationship seeking, stresses that the real relationship that unfolds between therapist and patient constitutes a major factor in the healing process. Just as it is the total primary relationship between a child and parent that forms a child's developing personality, it is the total relationship with the analyst, and not simply the transference, that permits significant personality change in the patient.

Greenson (1969; 1971) and Langs (1976; 1978; 1975) demonstrate most persuasively that it is the responsibility of the therapist to interpret nontransference reactions which might otherwise be attributed to the transference. Since all relations with others are mixtures between what is real and what is fantasy, what is appropriate and what is distorted, what is correct perception and what is inappropriate, what is nontransference and what is transference, it is only when the therapist is capable of making these distinctions nondefensively that the patient can begin to introject those healthy aspects of the therapist that enhance maturity. Demystification of the therapist and development of the patient's capacity

to sort out fantasy and reality occur concurrently when the therapist implicitly acknowledges real aspects of the therapeutic relationship, including acknowledgment of technical errors.

A fulcrum of feminist criticism directed at psychoanalytic technique is that in therapy, the patient is disempowered (as women are in society) and forced to allow others to be powerful over her/him. However, as I will explain, there can be considerable power and respect given to the patient and worked with in analytic therapy. Langs (1976; 1978) encourages us to marvel at and make use of the patient's unconscious sensitivity, creativity, and perceptiveness. In the atmosphere where the patient is permitted to say whatever comes to mind, where the sessions are allowed to unfold accordingly, and where the therapist maintains the framework of the therapy and provides a safe holding environment for the patient's feelings, the therapist must trust that the patient will unconsciously know what is best (Winnicott, 1971) and, in effect, trust that the patient will unconsciously "teach us how to do psychotherapy" (Langs, 1978, p.10). The therapist, if listening properly, will hear not only material to compose an interpretation, but also an indication when there is deviation from this goal (Langs, 1978). Therapists who recognize this unconscious relational quality, whereby the patient's health-seeking strength lead her/him to unconsciously act as supervisor or therapist to the therapist, demonstrate an aspect of psychoanalytic therapy consistent with feminist ideology: the reparative capacity resident in the patient and the active participation of the patient in the process of change are acknowledged; patients are empowered, arbitrary authority is reduced, and mutuality is enhanced.

Fairbairn (1940; 1941) informs us that the most profound knowledge an individual must acquire is that s/he has the capacity to receive love without being annihilated, and the ability to give love without destroying the recipient. The second of these capacities is most relevant to this discussion. To feel that one's love is not accepted by the parent is to learn that one lacks what is good to give (Fairbairn, 1941; Klein, 1975). Akin to this sense is the feeling that one's love is bad and destructive, a predicament so terrible that it threatens the child's ability to love at all. In an effort to protect the caretaker on whom s/he is dependent, the child withdraws from object relating, and consequently does not get what s/he needs. The child's anxiety (Klein, 1935; Winnicott, 1954; Fairbairn, 1941; 1944) at destroying and losing the mother is tolerated and modified only by the confidence that s/he can meaningfully contribute to her. Without this ability to give, a person is incapable of genuinely receiving (Winnicott, 1954-55; 1958; 1963).

Just as it is imperative that someone external to the self accept one's love in ordinary growth, so it is in the evolving therapeutic relationship (Winnicott, 1963). The underlying constructive aim, the developmental wish to be of use to the mother, occurs in psychotherapy as the patient's capacity to be of use to the therapist.

Searles (1975) suggests that all individuals have psychotherapeutic strivings and that any thwarting of one's capacity to love the other, to help the other fulfill her/his psychological and human potential, hinders one's own healthy development. Intrinsic to this notion is a powerful self-curative effort. In the infant, this striving serves to create a mother who is integrated, competent, and mature enough to properly parent, who can provide, in Winnicott's (1954; 1960) terms, good enough mothering

and a holding environment. In the patient, this endeavor assures that one will have a therapist who can contain anxiety, hold one's loving and destructive feelings, and hence firmly maintain the therapeutic framework in a way that will allow the therapist to properly aid the patient.

While there is ordinarily a conflict between the desire to be mature and fulfill one's individuality and the wish to remain in infantile symbiosis with the mother, this bind takes on pathological qualities when the parentified child, in expression of her/his deep love and loyalty to the mother, sacrifices individual maturity to aid the mother's functioning and make her a good enough parent (Searles, 1979). It is the child's compulsion to create a healthy mother, as well as the felt duty to be helpful to her, that fuels this regressive process.

To prevent a devastating reconstruction of the pattern which operated in the patient's childhood, where reparative opportunities were lacking or unacknowledged, the therapist must consciously comprehend the depth of the child's loyalty to the mother and the child's immense unconscious sense of guilt for insufficiently parenting the parent (Searles, 1979). This empowers the patient by recognizing her/his capacity for concern and natural therapeutic strivings (Winnicott, 1963). It also requires that therapists accept the reciprocal dependency, crucial to healthy adult relatedness, that unfolds between therapist and patient as it existed between mother and infant.

In addition to appreciating the reality components of the therapeutic relationship and the richly curative elements of the patient's unconscious perceptions of the therapist, a fuller consideration of the therapist's responsibilities is crucial to a blending of feminist values and psychoanalytic therapy. Langs (1975; 1976; 1973) attends to the hopefulness

and optimism buried in the patient's therapeutic strivings, but also directs his concentration to the negative aspects of the therapy that dictate a temporary role reversal of patient and therapist. He extends the notion of the patient's healing capacities to encompass the patient's supervisory attempts to alert therapists to their inevitable fallibility. Patients are credited with the unconscious sensitivity to detect and react significantly to the therapist's unconscious errors in conceptualization, understanding, technique or personal countertransference problems, even curing the therapist if the therapist's pathology impedes the way for the therapist to do the curing (Searles, 1979; Langs, 1976; 1975). Similarly, Little (1951) writes, "a patient may quite well become aware of real feelings in his analyst even before the analyst himself is fully aware of them." (p. 39). It is the therapist's task to bring these feelings into consciousness, despite their being "the very thing to which he himself has the greatest resistance." (p. 38). Acknowledgement of a temporary misalliance, along with analysis of the patient's reaction to it, will not only rectify the work, but will convey an appreciation of the patient's healthy and correct perceptions, allow the patient to meaningfully contribute to advancing the therapy, and establish growth and trust in the therapist.

It is unfortunate that a probing analysis of unconscious communications can seem unnecessarily rigid and that the exposure of patients' awareness of therapeutic errors can create so much anxiety in therapists. This demystification of therapists' power is actually quite a liberating notion. While it takes from therapists the fantasy of their omnipotence, it frees them from the burden of omniscience, and posits greater responsibility for the work on the patient, who invariably benefits from receiving

this respect.

With the goal of reconciling feminist values and psychoanalytic therapy, an examination of the patient's curative capacities has been presented. Hopefully, this discussion of how we can empower, respect, and trust patients for their conscious and unconscious sensitivity and caring, has contributed to a fairer conceptualization of psychoanalytic psychotherapy. Recognition of the therapist's humanness, fallibility, and unconscious conflict, as well as the patient's perceptions of counter-transference in the therapist and the patient's subsequent restitutive attempts, contribute to a more liberating clarification of analytic practice.

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